## INSTRUCTIONS FOR COMPLETING 210 ADJUSTMENT/VOID FORM (ADULT)

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<th>Adj/Void</th>
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<td>Adj/Void</td>
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<td>2</td>
<td>Patient's Last Name, First Name, MI</td>
<td>Adjust - Enter the information exactly as it appeared on the original invoice.</td>
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<td>5</td>
<td>Medical Assistance ID Number</td>
<td>Adjust - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim.</td>
<td>void - Enter the information exactly as it appeared on the original invoice.</td>
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<td>6</td>
<td>Patient's Address</td>
<td>Adjust - Enter the information exactly as it appeared on the original invoice.</td>
<td>void - Enter the information exactly as it appeared on the original invoice.</td>
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<td>7</td>
<td>Date of Birth</td>
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<td>Patient ID/Account Number (Assigned By Dentist)</td>
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<td>void - Enter the information exactly as it appeared on the original invoice.</td>
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<td>16</td>
<td>Pay to Dentist or Group</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
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<td>17</td>
<td>Pay to Dentist or Group Provider No.</td>
<td>Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim.</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
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<td>18</td>
<td>Are X-Rays Enclosed</td>
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<td>19</td>
<td>Treatment Necessitated By</td>
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<td>20</td>
<td>Payment Source Other Than Title XIX</td>
<td>Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code.</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
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<td>Enter the information exactly as it appeared on the original invoice unless this information is being adjusted.</td>
<td>Enter the information exactly as it appeared on the original invoice.</td>
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<td>24</td>
<td>Paid of Payable by Other Carrier</td>
<td>Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party</td>
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insurer. If such payment has been made, indicate the amount paid, even if zero ($0).

Void - Enter the information exactly as it appeared on the original invoice.

25 Other Information
Leave blank.

26 Control Number
Enter the control number assigned to the claim on the Remittance Advice that reported the paid or denied claim.

27 Date of Remittance Advice
Enter the date of the Remittance Advice that paid or denied the claim.

28 &
29 Reasons for Adjustment/Void
Check the appropriate box and give a written explanation, when applicable.

30-31 Leave these spaces blank.

32 Attending Dentist's Signature - Provider Number
All adjustment forms must be signed, and the provider number must be entered.

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Molina for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.
## Provider Billing Form for Adult Dental Services

### Patient Information

1. **Patient's Last Name (Print)**
2. **First Name**
3. **MI**
4. **Medical Assistance I.D. Number**
5. **Date of Birth**
6. **Sex**
7. **Referring Agency No.**
8. **Date of Referral**
9. **Physician**
10. **Address**
11. **Telephone No.**
12. **Referring by:**
13. **Signature**
14. **Telephone No.**

### Patient's Address (Street Number, City, State, Zip Code) (Tel. No.)
- **City**
- **State**
- **Zip**

### Payment Information
- **Pay to Dentist or Group**
  - **Name**
  - **Address**
  - **Provider No.**
  - **Telephone No.**
  - **Patient I.D./Account # Assigned by Dentist**

### Treatment Neccessitated By
- **Employment**
- **Accident/Injury**

### Treatment Details
- **Description of Service**
  - **Facial Information**
  - **Oral Cavity**
  - **Tooth #**
  - **Usual and Customary Fee**
  - **Adjusted Fee**
  - **Paid or Payable by Other Carrier**

### Additional Information
- **Date of Birth**
- **Sex**
- **Referring Agency**
- **Referral Date**
- **Physician**
- **Address**
- **Telephone No.**
- **Provider I.D./Account # Assigned by Dentist**

### Certification
- **I have read the certification on the reverse of this form and do hereby certify that I am in compliance therewith.**
MEDICAID PAYMENTS: I HEREBY AGREE TO KEEP SUCH RECORDS AS ARE NECESSARY TO DISCLOSE FULLY THE EXTENT OF SERVICES PROVIDED UNDER THE STATE'S TITLE XIX PLAN AND TO FURNISH INFORMATION REGARDING ANY PAYMENTS CLAIMED FOR PROVIDING SUCH SERVICES AS THE STATE AGENCY OR ITS AUTHORIZED REPRESENTATIVE MAY REQUEST FOR FIVE YEARS FROM DATE OF SERVICE. I FURTHER AGREE TO ACCEPT, AS PAYMENT IN FULL, THE AMOUNT PAID IN ACCORDANCE WITH THE FEE STRUCTURE OF THE MEDICAID PROGRAM FOR THOSE CLAIMS SUBMITTED FOR PAYMENT UNDER THAT PROGRAM.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I CERTIFY THAT THE SERVICES LISTED ON THE REVERSE WERE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THIS PATIENT AND WERE PERSONALLY RENDERED BY ME OR UNDER MY PERSONAL DIRECTION.

NOTICE: THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE.

I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS.